Brookhaven ORTHODONTICS

PATIENT INFORMATION

Date_____ Gender_____ Age_____

First Name_____ Middle name_____ Last Name_____

Preferred Name_____ SS#_____ Date of birth_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Cell phone_____ Work phone_____

Email for appointment reminder_____

Emergency contact_____ Relationship_____ Phone number_____

Name and ages of all children in family_____

Have Any Been Seen in our office? ☐ Yes ☐ No

PARENT INFORMATION

(Please complete if patient is a minor)

Father's name_____

☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SS#_____ Date of birth_____

Phone_____ Work Phone_____

Email_____

Occupation_____

Employer_____

Mother's name_____

☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SS#_____ Date of birth_____

Phone_____ Work Phone_____

Email_____

Occupation_____

Employer_____

RESPONSIBLE PARTY INFORMATION

(Please complete if patient is an adult)

First Name_____ Middle name_____ Last Name Preferred Name_____

SS#_____ Date of birth_____ Phone_____

Employer_____ Position_____

Spouse Name_____ Spouse Employer_____

Spouse SS#_____ Spouse Date of birth_____ Spouse Phone_____

DENTAL INSURANCE INFORMATION

Primary

Policy Holder_____

SS#_____ Date of birth_____

Employer_____

Insurance Company_____

Insurance Phone_____

Group/Policy Number_____

Member Subscriber ID_____

Secondary

Policy Holder_____

SS#_____ Date of birth_____

Employer_____

Insurance Company_____

Insurance Phone_____

Group/Policy Number_____

Member Subscriber ID_____

Do you have insurance that covers orthodontic treatment? ☐ Yes ☐ No ☐ Don't know

GENERAL INFORMATION

When was the last time you visited a dentist office?_____

Dentist name_____ Phone number_____

Who may we thank for referring you to our practice?_____

How many different ways have you heard of our practice? ☐ Friend_____ ☐ Patient_____

☐ Website/Internet_____ ☐ Ins. plan_____ ☐ Employee_____

☐ School_____ ☐ Community_____ ☐ Direct mail_____

☐ Yelp_____ ☐ Billboard/office sign_____

Who suggested that you may need orthodontic treatment?_____

Why did you select our office?_____

What school does the patient attend?_____ Grade_____

List Interests and hobbies_____

HEALTH HISTORY

The following questions are designed to obtain your health history and to help us understand what you want to achieve from orthodontic treatment. We will confirm this information when we present your treatment options.

Does the patient have or ever had any of the following? (Please check all that apply) ☐ Diabetes ☐ Rheumatic Fever ☐ Thyroid/Endocrine ☐ HIV/AIDS ☐ Asthma ☐ Bone Disorders ☐ Anemia ☐ Hepatitis ☐ Cancer ☐ Sleep Apnea ☐ Epilepsy ☐ Heart Disease ☐ Autism ☐ Prolonged Bleeding ☐ Faintness/Dizziness ☐ Nervous Disorders

☐ Yes ☐ No Does patient require antibiotics prior to treatment?

☐ Yes ☐ No Is patient in good health?

☐ Yes ☐ No Has there ever been trauma to the patients face/teeth? Explain_____

☐ Yes ☐ No Is the patient presently under the care of a physician for an illness or disease?

☐ Yes ☐ No Does the patient have a bleeding tendency or do wounds heal slowly?

☐ Yes ☐ No Is the patient allergic to nickel, latex, drugs or medications? List_____

☐ Yes ☐ No Is the patient taking any medications? List_____

☐ Yes ☐ No Is it necessary for the patient to pre-medicate before dental appointments?

☐ Yes ☐ No Any medical, dental or surgical problems not covered above? If so, list_____

Check all statements below that apply to the patient:

The Teeth

☐ There are spaces between the teeth that I do not like

☐ The teeth are crooked and overlapping

☐ The teeth stick out too far

☐ The mouth seems too small, not enough room for the teeth

☐ The teeth are coming in the wrong places

☐ Not aware of any problems

The Bite

☐ The bite is comfortable and I can eat what I want with no difficulties

☐ I feel there is a problem with the bite or I have been told there is a problem

☐ I have frequent or chronic pain in my jaws, face or head

☐ My jaws click, pop, or lock when I open my mouth

☐ I have or have had difficulty in opening or closing my jaws

☐ I clench/grind my teeth during the day/night

The Dentist

☐ I visit the dentist regularly, at least every_____ months

☐ My last cleaning was in the month of_____

☐ I have not seen the dentist for over a year, I am due for a cleaning

☐ It has been_____ years since I had my teeth checked by the dentist

Orthodontics

☐ This is my first experience with an Orthodontist

☐ The patient has worn braces before

Previous Orthodontist_____ Year_____

☐ I have seen another Orthodontist and I would like a second opinion

Orthodontist Name_____

What Kind of Braces are you interested in?

☐ Traditional (silver metal)

☐ The most cosmetic (clear ceramic, or lingual-behind the teeth)

☐ Removable and Cosmetic (Invisalign)

☐ I need more information to make a decision

How soon would you like to get started?

☐ I would like to get started as soon as possible if it's determined that treatment is indicated

☐ I want to discuss the findings with my spouse before making a decision to start treatment

☐ I want to delay treatment as long as possible

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